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Taking Command

In this issue of the *Journal* you will find an "open letter" written by Grace Mitchell Fairley, recently elected by acclamation to be President of the Canadian Nurses Association. In that letter Miss Fairley sends her greetings to the nurses of Canada and refers briefly to the many implications of the new task to which she brings so many of the necessary qualifications.

And now what of the woman whom Canadian nurses have chosen to guide the destinies of their national Association? What like is she — as they would say in her native Scotland? She has dark hair and bright eyes, a quick and friendly smile, a pleasant voice with a delightful accent which betrays her Scottish origin. She likes people and seeks to understand them and is therefore easy to approach. This, and a delightful sense of humour, are the secrets of her charm.

So much for the personal side — now for the professional. Miss Fairley is a graduate of the School of Nursing of the Swansea General Hospital, and after experience as a Ward Sister, became the Assistant Matron of the Glasgow City Hospital. Leaving Scotland for Canada, she was appointed lady superintendent of the Alexandra Hospital, Montreal, and afterwards served successively as superintendent of nurses at the Hamilton City Hospital, and the Victoria Hospital, London, Ontario.

In 1929 Miss Fairley accepted the position she now occupies with such conspicuous success, as director of nursing and principal of the School of Nursing in the Vancouver General Hospital. Under her direction an excellent teaching department has been organized and she has gathered about her an enthusiastic and well prepared staff. Several of the young women whom she has helped to develop, now occupy key positions in other institutions.

Miss Fairley has always displayed keen interest in nursing organizations. She was president of the Nursing Education Section of the C.N.A. for four years and is still the president of the

Registered Nurses Association of British Columbia. She has recognized the importance of keeping in friendly touch with hospital associations. For two years she served as a vice-president of the American Hospital Association and now takes an active part in the work of the British Columbia Hospitals Association.

Strongly British in her sympathies, Miss Fairley is a member of the College of Nursing and of the British College of Nurses. She has done excellent work on behalf of the Florence Nightingale International Foundation and is actively interested in international nursing affairs.

Possibly one of the most outstanding qualifications for national leadership which Miss Fairley possesses is the fact that she has held administrative positions in three of the widely separated provinces of the Dominion. She knows, by actual experience of them, the problems peculiar to the province of Quebec — knowledge which will be most useful to her as our national president. She has lived and worked in Ontario, and for the past ten years has been learning the way of thinking which is characteristic of British Columbia.

A preparation such as this is invaluable for a woman upon whose shoulders is placed the heavy burden of national leadership — but as Miss Fairley herself says in her "open letter", there are many cross currents in the stream of our national life the influence of which inevitably makes itself felt in our professional organizations. It would be folly to ignore their presence even were it possible to do so. The part of wisdom is to recognize their potentialities as a driving force and by careful steering, to utilize them for the advancement of nursing in Canada.

It has been said by a friendly critic that Canadian nurses flatter themselves that in them may be found a combination of the best features of British, French and American nursing. While we should not be smug about it, perhaps we are justified in claiming that there is an element of truth in this gentle sarcasm. It would be strange if there were not — certainly we have been exposed to the influences of all three nationalities and should have profited thereby. However that may be, it cannot be denied that the Canadian Nurses Association has come to occupy an honoured place in the International Council of Nurses. The influence of our thinking, the weight of our opinion becomes more apparent with every year that passes. This highly desirable situation has come about because for many years the Canadian Nurses Association has been extremely fortunate in its choice of leaders.

One word more — sound leadership implies loyal and unwavering support — and here we touch upon the unselfish and often tedious work consistently carried on by the various committees of the Canadian Nurses Association. Turn again to the September number of this *Journal* and note how wide is their scope and how great their accomplishment. Able leadership, yes, but also a rank and file which carries on without much hope of recognition, and simply for the good of the cause. The work of these committees in every Province of the Dominion constitutes, in the aggregate, a large measure of the achievement of the Association as a whole. If you take an active part in the work of national, provincial, or local committees you are indispensable because it is to you that our leaders must look if the future of the Canadian Nurses Association is to be worthy of its honourable past.

The new President begins her task. She may count upon every one of us to help her!

An Open Letter

GRACE M. FAIRLEY

President, The Canadian Nurses Association

In conveying the greetings of the new executive to the members of the Canadian Nurses Association, I do so with considerable pleasure, if with some misgiving—misgiving that, in an open letter, I may fail to voice the sincerity of purpose of the individual officers whom you have appointed to guide the affairs of our National Association during the next two years.

Of necessity, such a change in executive personnel must bring certain changes in régime, but these will not be fundamental. Those of you who heard Miss Simpson review in her presidential address, our "Thirty Years of Growth" will realize that in these thirty years—a generation in the scheme of things—a wonderful foundation has been laid for future development and therefore, with the support of the nine provincial Associations, we take courage.

One wishes that the enthusiasm felt at such a Biennial Meeting as the one just concluded at Halifax, could be carried to each member. Thus would our association become truly alive. Those who were present, both provincial delegates and members, expressed very definite views and accepted responsibility by passing certain resolutions which were published in the September number of the *Journal.* These resolutions will affect both policy and progress during the next two years, in which all provincial Associations must share.

Well might we review the work of the presidents and committee chairmen of the past thirty years and give more than a passing thought to some of the problems likely to arise in the next few years, and well might we hope for inspiration and courage in trying to solve them. Each member of the Canadian Nurses Association has a trusteeship in the Association and only through a knowledge of its objects, its functions and its obligations can we, as trustees, feel assured of the continued soundness of its policies and its success in the future.

It was made clear at the 1938 Biennial Meeting that such vital matters as the hours of duty and the working conditions of students and graduates must be the responsibility of the Canadian Nurses Association. This means the considered opinion and concerted action of all provincial Associations and, in the final analysis, the opinion of every registered nurse. In an address recently given by our international President, Miss Effie Taylor, she said, "You and I are the 'nurses' to which we are wont to refer, and it is we who must share the joys, shoulder the burdens, and assume the responsibilities which are thrust upon ourselves and our professional colleagues". This is as true of the individual members of the Canadian Nurses Association as of the group to which Miss Taylor was addressing herself.

The Canadian Nurse, our official organ, was much in the limelight, both in the sessions and by means of the excellent exhibit for which we are indebted to the Registered Nurses Association of Ontario. Great emphasis was put upon the fact that to no other magazine could we look for the interpretation of Canadian nursing and professional thought and progress. To you, the members, we look for that support which alone can make our *Journal* a real professional success. It is yours, it is ours!

One cannot read contemporary journals these days, whether hospital administration, public health, or nursing, without realizing that the problems assailing us are absurdly similar to those affecting similar groups in this and other countries. In these days of economic anxiety and suspense which are forcing social, labour and financial legislation on the institutions and organizations with which we as nurses are most closely in touch, we must enlist the interest and support of our younger members in preparing themselves for professional responsibilities. At no time in the world's history has it been more important for those of us who play a part in the programme of life and health conservation to retain our mental and physical poise. If there is anything that we can hand on through our national Association (whose object is service) that will help in the promotion of stability of thought and action, whether affecting our Provinces or our Dominion, it is our duty to do so.

May I remind you that we cannot divorce our Provincial Registered Nurses Associations from the Canadian Nurses Association. The Canadian Nurses Association is a federation of the nine provincial Associations, and therefore we must not think in terms of East or West, but rather of what will help to develop nursing throughout Canada, whether rural or urban, so that we may meet the rapidly changing community needs of our Dominion.

New Officers of the C.N.A.

At the General Meeting of the Canadian Nurses Association several outstanding nurses were elected as the officers for the coming biennial period. The first vice-president is Elizabeth L. Smellie, C.B.E., R.R.C., Chief Superintendent of the Victorian Order of Nurses for Canada who, when she received the award of the Snively medal at the Halifax Meeting, was spoken of as our very competent though unofficial ambassador to other professions and to the public at large. The contacts which she makes while travelling about the country in her official capacity are invariably beneficial, not only to the Victorian Order of Nurses but also to the nursing profession at large. An excellent sketch of Miss Smellie's career, written by Miss Jean I. Gunn, appeared in the June issue of the *Journal*. This constitutes a record of an accomplishment so remarkable that it more than justifies the choice the Association has made.

The office of second vice-president was offered, by acclamation, to Marion Lindeburgh. One of the most important tasks ever carried out under the auspices of the Canadian Nurses Association was the preparation of the Proposed Curriculum for Schools of Nursing in Canada. Only those who watched this project at close range can appreciate the enormous amount of work which it entailed. To this project Miss Lindeburgh has devoted her energies over a period of several years and even though the *Curriculum* is now published and in active use all over Canada she still strives to broaden and increase its usefulness.

Elizabeth L. Smellie

Miss Lindeburgh is the director of the McGill University School of Nursing and has been an inspiration to the students who have come within the sphere of her influence. The prestige of the School and the scope of its activities are increasing from year to year and its success is due in a very large measure to the fine qualities of its director. When free from professional responsibilities, Miss Lindeburgh enjoys a fast game of badminton or climbing a peak in the Rockies. Her reputation as a hostess is well deserved and she is, incidentally, an expert cook.

The office of honourary secretary of our national Association is far from being a sinecure and Miss Kathleen I. Sanderson brings to it a wealth of secretarial experience. Miss Sanderson was born and educated in the Maritimes, took her professional training at the School of Nursing of the Royal Victoria Hospital, Montreal, and subsequently a post-graduate course in public health nursing at

Marion Lindeburgh

the McGill University School of Nursing. After holding various staff positions in her own School, Miss Sanderson became assistant director of nursing in the Vancouver General Hospital. Later she returned to the field of public health and served successively as field worker for the Canadian National Institute for the Blind and for six years as executive secretary of the Greater Vancouver Health League. Miss Sanderson has many interests outside the professional field, her special favourite being the study of the French language. She likes dogs, and is an expert in pottery.

The Canadian Nurses Association has been happy in its choice of an Honourary Treasurer. Miss Alena J. MacMaster enjoys the enviable reputation of being an extremely able hospital administrator, a career which requires a firm grasp of business principles as well as expert knowledge of hospitals and their peculiar problems. Miss MacMaster has built up the Moncton General Hospital to a high degree of efficiency and enjoys the respect and admiration of her colleagues in the hospital field. She also displays keen interest in nursing service and is well acquainted with the problems of the training school. The making of budgets and the wise administration of the funds of the Association could not be under better guidance than hers.

This year the Canadian Nurses Association took the wise step of appointing the immediate Past President of the Association as a member of the Executive Committee. Those who are familiar with nursing organizations whose membership is scattered over a wide area, will realize the advantage of making the counsel and assistance of the retiring president available to the incoming executive. No one is better informed concerning the Association and its problems than Miss Ruby M. Simpson, and she will thus be able to render most valuable service, not only to her successor but to the Association at large.

Our National Association begins its next biennial period with the assurance of capable leadership. Though there are difficult problems awaiting solution and many responsible tasks to be undertaken, we need have no anxiety. The affairs of the Canadian Nurses Association are in safe hands.

The Other Side of Records

FRANCES KING

Supervisor, Local Health Records, Department of Health, State of New York

No matter how easy we may make the methods, writing up family histories will always be a burden. The nurse puts in a full day of visits and comes back to the office feeling that she has done a good day's work. Then she has to sit down and go over it all again. Making notes in the home helps her to some degree, but there is still much that has to be done in the office. Modern inventions have simplified the process considerably, but there is still a great deal that has to be done in longhand. Fountain pens and the type of paper we use may have speeded up that method somewhat, but our actual writing is probably not so very much more rapid than that of our ancestors.

If we go back far enough, we can find evidence that we have gained speed. Probably it took the scribes at the temples in Epidaurus, several hundred years before Christ, as long to write their simple "clinical records" as it does one of you to write up a complete nursing visit. These inscriptions at Epidaurus are the earliest patient records known. We do not know whether or not the physicians or priests wrote their orders, but upon the columns were inscribed the names of the patients, brief histories of the cases, and comments as to whether or not they were cured. A little later, Hippocrates wrote true and detailed clinical records and wrote them well. But Hippocrates was not hampered by having to fit his records into a pattern formed by what had gone before. He recorded what he thought was necessary — what his own sense and intelligence dictated. There are two good reasons why we cannot make records in the same way. One is that few of us have the intelligence or foresight to record items which are not pertinent or important to the present aspect of the case but which may be invaluable later. The other reason is that we must have a certain amount of data upon which to base comparisons.

Upon records, two distinct plans must be based. The nurse must use the history of the individual to plan her work for that person in the future, and the administrator must be able to utilize a group of nurses' records to make plans for the work as a whole. Standards of comparison are built up from individual cases. The gain in weight of one baby would mean nothing at all if it could not be compared with the normal gain, as determined by the records of many workers. In other words, many workers must gather uniform data from many cases in order to establish a basis of comparison. It is necessary to choose the important facts, for we do not have time to list everything. That is a danger we must watch against. We are prone to list items that are of negligible value for fear of missing something which conceivably might be of use. It is quite possible for clear thinking to be swamped by a multiplicity of non-essential items. An attempt should be made to distinguish significant facts, and a little thinking should precede the writing. The headings printed on the history forms cannot be ignored, for these items are there because the records compiled by our predecessors have proved that they are worth writing down.

One mistake that is frequently made in drafting record forms is an attempt to cover too much ground. The fewer items that it is necessary to record, the more complete and accurate the record will be in the end. In many places today specific headings are largely omitted from the history forms. Instead of providing places where the items may be coded or checked, the nurses are requested to write narrative histories and are given as a guide a list of things for which to watch. This method permits much more flexibility and through it the changing problem is more likely to become apparent. On the other hand, it requires a great deal of supervision and training and demands a nurse who is intelligent enough to detect the important aspects of each and every case.

I believe that the ideal record would be half way between the narrative and the coded forms. There are certain items which are almost universal in certain types of cases. For example, the supervision of an antepartum partient demands that certain items be checked upon visit after visit. I can see no reason why the nurse should have to spend time making narrative notes for these points, when check marks or a code would serve the same purpose.

Several types of codes are used. One which is in common use is G., F. and P. for good, fair and poor. Another employs X's, X indicating satisfactory, XX moderately satisfactory, and XXX unsatisfactory. The simplest code of all, however, seems to be using numbers as well as symbols:

0: condition normal.
1: slightly unsatisfactory condition.
2: moderately unsatisfactory condition.
3: markedly unsatisfactory condition.
-: item not applicable or no information available.
x: needs medical attention.
00: condition corrected.

When this code is used, a multiplicity of "threes" calls attention to the fact that there are a number of unsatisfactory conditions on this particular history, and a succession of "threes" on the same item entered upon successive visits shows plainly that nothing has been done to remedy the defect. It is usual when codes are used to require that the entry of a symbol indicating an unsatisfactory condition be amplified by notes in the narrative portion of the history.

Abbreviations are akin to codes and, if used wisely, will save a great deal of time. Too frequently, however, abbreviations are manufactured at will and a contraction which is perfectly clear to the inventor means nothing at all to the unfortunate nurse who has to decipher her predecessor's notes. None the less, abbreviations can save so much time, both in writing and reading, that it pays to have what might be called a table of recognized and standard abbreviations, which are not only expected, but required to be used.

Where the narrative history is used alone, it is customary to require one or two things. Either the nurse must enter the important details in red, or she must periodically summarize the problem and the situation also in red. The former method seems to me clumsy. It is not easy to remember to drop a fountain pen and change to red ink in the middle of an entry. I like the latter method better. For one thing, it compels the nurse to sit down and thoughtfully review what needs to be done, what has been done, and what has not been done, in each of her families. It is a time-consuming task, but an occasional inventory of this sort crystallizes in a nurse's mind the problems with which she has to deal and makes her home visiting easier because she has had to analyze the case in order to make the summary.

Another method of summarizing which is not used extensively but which has been found satisfactory by the organizations using it, is to have on the front of the individual history three columns headed "problems", "plan" and "progress". If this is kept up-to-date, it saves a lot of time, for the nurse can refresh her memory before making a visit without having to look over a mass of notes. More than this, the supervisor can tell at a glance whether the patient really needs supervision, whether the nurse is taking the proper steps, and whether she is doing productive work. This arrangement also makes it necessary for the nurse to think about what she is doing in that particular case and to formulate a definite plan of procedure.

Only a handful of people are born with a proper respect for records — they have to be shown, and this periodical analysis and summary is one of the best ways of teaching. It gives point to the review of a record by the supervisor and gives the young nurse a better conception of her task. Too cut and dried a formula for recording may eliminate much valuable information, and too great insistence upon the importance of recording facts only may be a disadvantage. There are times when an intelligent impression is more productive in solving a family problem than all the facts a nurse can gather in a dozen visits.

This does not mean that we should let our imaginations run away with us and clutter up the records with items which would be misleading later on. A little colour and life in a nursing history sometimes adds to its value, but too much of that sort of thing can degenerate into flippancy and inaccuracy. As a matter of fact, some of the most amusing entries encountered in nurse histories are quite unintentional. I recall an entry made by a nurse who was sent to investigate a case where a woman who was not registered as a midwife had attended a birth. The nurse's entry on the case read as follows:- "Mrs. B. stated that birth was accidental and promises that it will not happen again."

One thing it is essential to be careful about. If an inference is included in a record, it should be made plain that it is an assumption, not a fact, and some indication of the reasons for believing it should be given. It is not necessary to justify a factual entry, but it is essential to explain why a suspicion is worthy of being recorded. It is dangerous business to trust to memory and even more dangerous to include inferences that may be false or misleading. The nurse will need later on, and the nurse who takes over the case after her will need even more, evidence that is a dependable basis for constructive work.

One cannot think or plan without observation, and observations are wasted if they are not recorded. In the words of John Stuart Mill, it is necessary "to judge of evidence and act accordingly." Effective work cannot be done without an object in mind. The definition of an object is: a thing having a definite significance. Our objectives should meet that definition. Every once in a while we accomplish something which seems to have come about by accident, and history tells us of great discoveries that apparently have come about that way. But history also tells us that the person who made that accidental discovery had a background of training which prepared him for it. Records are our background. Intelligently kept and intelligently used, they eliminate haphazard, fruitless effort and provide instead a basis for planned and productive effort.

We cannot develop an effective programme unless we know what we are faced with, and can draw upon past experience. Our records not only should show results but the reasons for those results. If we fail, isn't it helpful to know why we failed, and with a failure, doesn't it soothe our feelings to look over a record and see that all was done that could be done? Analyzing and criticizing past work is not a morbid occupation, if it is done properly. A critical attitude toward our own efforts is a very different thing from dwelling on our failures and twisting and turning them over in our minds, wondering if we should have done this instead of that.

Good records should show what methods are most effective, most economical of time and of most lasting value. The public health field is constantly widening. In the beginning it was simpler. We began with tuberculosis and well baby clinics. The care of the baby led naturally to prenatal care. There was no popular demand for this service. It had to be introduced. And if the first introduction didn't take — and usually it didn't, it had to be introduced a few times more. Now it is a different story. Let someone once broadcast the news that some disease — syphilis, cancer, pneumonia or what have you — is really a public health problem, and the popular magazines and the insurance companies pounce forth with all their bugles blowing. And Mr. and Mrs. John Public accept it — not, of course, as something that applies to them, but as something that applies to their neighbours. In fact, instead of our having to "drive" public health home, public health is now driving us.

To meet these demands, we sometimes have to work faster than we like but if our records of past work are honest and true, ideas, knowledge and experience will fall into line, ready to meet the changing conditions. The fundamental techniques for visits in general are more or less uniform, and can be adapted to the new problems without much difficulty.

Frequently the nurse enters a home for the first time because of an acute condition and, if she is observant, discovers conditions not so obvious, which in the long run require more thought and care than the acute illness. That is why it is well to start a family history for all except the most simple cases. It is not as easy to write up a family history as it is to write an individual record. It takes time and patience to get the names of the members, their ages, the socio-economic data, and the past history which may be needed later on. Sometimes all of them can be gathered on the first visit, but it is better not to force the issue if the family is upset, or not any too sure that the nurse is there to help them. Frequently the nurse has to get her information in a roundabout way, or has to visit until the family has accepted her enough to put up with the foolish questions that so far as they can see, have nothing to do with the case.

This brings up the question of making notes in the home. At the present time there are few organizations which do not insist that the nurses make their entries on the family histories during the visit. The nurses themselves seem of two minds about the advisability of this. In some cases they feel that it helps them, for it gives the family a feeling of importance to know what they say is being written down so carefully. In other families, the fact that notes are being taken embarrasses the speaker. Personally, I do not see how it is possible for a nurse to listen, ask the wise and timely question, keep her eyes and ears open for the little incidentals that are so valuable, and build up confidence, while she is trying to make an accurate record of what the mother says. There is also the difficulty encountered when some member of the family gives her information which the nurse enters and then has to change later when the patient changes his mind unexpectedly.

On the other hand, it is not easy to remember accurately without making notes the various items that are learned in the course of the visit. It might be suspected that I am dodging the issue. I am. I know taking notes in the home is one of today's most popular styles, and I am not going to commit myself by saying whether or not it is a style that will endure. For, after all, accurate data is the only kind worth recording at all, and useful data is the only kind worth bothering to get accurate. The nurse in the field is not allowed a great deal of discretion as to the items she must record about each of her families. We must have information that is comparable for groups of families, even if it means writing on a family history items that do not seem to be needed for the supervision of that particular family.

For that reason, it is very necessary that the administrator make sure that the items asked are truly useful and not just traditional. They should be checked over once in a while. Why were they put there? Have they ever been used? Should they be used? What would they show if they were tabulated? If they were tabulated, would the table tell us anything helpful? Are they helpful to the nurse who is visiting that family? Are there any of these items that it is almost impossible to get answered accurately? Why? Can their significance and value be made apparent to the nurse who has to keep the record?

Work is enriched if it leads somewhere — if it amounts to something. No nurse, no matter how tiresome she finds the making of records, will do them in a slipshod fashion, if she knows that they are stepping stones and not stumbling blocks. If we are sure that the information we require is truly useful, we should be able to show the new nurse that making accurate and dependable records is worth the doing. If we know why we are doing a thing, we can take it — and even take it and like it. Records honestly devised and honestly kept will help us:

To meet present needs
To plan for the future
To prove accomplishment
To demonstrate effective methods
To maintain a balanced and serviceable programme

Editor's Note:

This article is the text of an address delivered during the sessions of a Refresher Course, dealing with the subject of records, given under the auspices of the School of Nursing of the University of Toronto.

STIMULATING COMMENT

It is encouraging to find that the Special Convention Number of *The Canadian Nurse* has met with distinct approval in many parts of the country. So many kind messages have been received that it would take another special edition to publish them all and we are therefore reduced to quoting just a few.

One of the most welcome came from Dr. Helen MacMurchy, the first editor of *The Canadian Nurse,* who knowing, from experience, something of our editorial trials and tribulations says "Congratulations, to you and all the contributors, on the September issue. It is a magnificent number".

Miss Jean I. Gunn has this comment to make:

> I think it is a very excellent number. I am very glad that the papers, reports, etc., from the biennial meeting were all published at the same time. I feel that when they are published over an extended period that interest is lost. In addition to this, it is not nearly as good a reference when the papers are not published together.

Another interesting response comes from Mrs. Irving E. Robertson, president of the Canadian Mothercraft Society:

> We are very interested in Dr. Atlee's address, as we feel that midwifery is extremely important for better maternal and child care. It is of vital importance to the future health of the citizens of Canada, and other countries of the British Empire are alive to the great value of nurses in the education of the mother. We will continue to send Mothercraft nurses outside the country for their post-graduate midwifery until such time as there is a midwifery training school in Canada working from the normal aspect.

Miss E. Frances Upton, executive-secretary and registrar of the Association of Registered Nurses of the Province of Quebec, goes (as usual) to the root of the matter when she writes:

> I feel that we members of the Canadian Nurses Association should be very proud indeed of this achievement, which is a proof of what our *Journal* could be if only we had sufficient faith and courage to render to it the support it deserves.
>
> The August and September numbers of our *Journal* contain all materials, admirably and concisely arranged, upon which the constructive thinking and planning of our work during the coming two years at least should be based, and in my humble opinion they fully justify all costs involved.

Miss Florence H. M. Emory who, as convener of the Publications Committee from 1932 to 1938, always displayed great interest in the development of the *Journal*, sends this message:

> Let me add a word of praise for the September issue of the *Journal*. It is one thing to hold a convention and quite another to have such an effective medium for informing those not there of the significant proceedings. The effort to do this is worthy of heartiest congratulations.

From Montreal to Vancouver is a far cry and it takes five whole days for the *Journal* to reach the President of the Canadian Nurses Association. But, when it came, Miss Fairley's word was encouraging: "The September issue has just come in. All here feel that it is most successful, *especially those who were present at Halifax*". The italics are ours, and show that those best able to judge apparently are well satisfied.

By way of conclusion, we quote from a letter written by a young nurse who is doing some real thinking:

> The August number was such a good résumé of a meeting which was a great experience for a young and *not* important nurse. It is a great pity that more of the younger women, who may be at the head of affairs some day, cannot afford either the time or money to attend. So many of them think the meetings are only of interest to the older nurses, *being so much run by them*, but until the younger nurses are better represented this seems the only course possible.

Once more the italics are ours. Yet, until the younger nurses are willing to take the buffet and cushion the shock, can they qualify for leadership? We wrote an article once in defence of "Those Old Dames", and we now feel strongly tempted to write another, but with a different title. We shall call it "Youth at the Wheel—*if you can get them to take it*"!

The Community Aspects of Poliomyelitis

GRETTA ROSS

Ontario Society for Crippled Children, Toronto

As a result of the 1937 epidemic, we have in Ontario 588 individuals with some residual paralysis. To many of these, muscle power is slowly but surely returning. Unfortunately, others will carry the resulting handicap for the rest of their days. Because of our lack of knowledge of the cause of polio we are apt to feel helpless regarding the crippling, but we must remember that while crippling due to polio may be unavoidable, deformities can be prevented by proper care and that much of the responsibility is ours, especially in the matter of health teaching in either hospital or home.

The community worker, whenever possible, should obtain for the attending surgeon in hospital a social report such as will give him a complete picture of the home situation. The type of home, the financial conditions, the degree of intelligence of the mother, her willingness to co-operate and the type of nursing care that she will probably be called upon to give, are all important factors. Is the attitude of the mother going to be one of optimism, of patient kindly understanding toward the patient who will sooner or later come to the realization that his disability is going to be one of months, or possibly years? We must be alert, not only to the patient's reactions, but to those of the parents and be as willing to give leadership by aiding them to reach a proper frame of mind as we are to assist them in adjusting themselves to the discouraging slowness of recovery.

Instructions to the mother in bedside care are often a bit difficult especially in rural areas and the community worker must plan to accomplish much on her infrequent trips. She must familiarize herself with hospital routine, and with the working of the new appliances and splints which may go home with the patient. She must help the parents to improvise with what little they may have. The child needs physiotherapy, but lives far from a hospital centre or from the areas in which the Red Cross physiotherapy service is available. He must have massage daily and yet frequent visits of any health worker are out of the question. Then the mother must do her best. True, the nurse is no physiotherapist, but she does know the things which training and ordinary common sense can help her to pass along.

Is it just as necessary to know how to remove a splint as it is to know how to lift a paralyzed limb when the splint is being removed, and to support it when the splint is off, as well as how to bathe a post-polio patient without damage to the affected parts. There are probably many of us who have never nursed a polio patient but have we not all nursed paralyzed patients? We know the dangers of contracture of the knees or hips and that we must protect the patient from drop foot caused by the weight of bed clothes. We know that early massage must not be carried to the point of pain or exercise to the point of fatigue. We must be able to explain the reasons for the use of frames, splints and sand bags and must keep in close touch with the private physician or clinic under whose supervision the patient may be.

Those of us who have done post-folio follow-up work in previous years can see problems and arguments all along the line for the next decade. The boy with the damaged deltoid, wearing an awkward splint, returns home and, by the time the nurse gets around to him, the kindly neighbour will have explained to the mother that any limb becomes useless from disuse. The argument sounds logical and the mother removes the splint, thereby destroying perhaps forever the good results of weeks of treatment. Many of these difficulties may be overcome by getting on the job early and sticking to it. Exercises, so important during convalescence, are simple at first, but soon become a frightful bore. Day after day, and month after month the mother can see little improvement, but an interested visitor can discern it and a little encouragement will go a long way.

The mental adjustment of the child cannot be stressed too much. The boy who has been in hospital for a long period is quite an important personage. He knows all the technical terms for his condition, and the mechanism of his new splint is quite intriguing. Then he goes home and, after the first few days, his mother with her large family has little time to bother with him. If the child be discharged to a good home the results are often worse, for here he is swamped with sympathy and attention. Discipline becomes an unknown quantity, temper tantrums may appear, he may become selfish and self-assertive—a most unpopular member of the community.

A wise mother allows a normal child to develop by giving him a certain amount of freedom. He gains his independence and courage with the help of the kindly understanding of his parents. But these same parents may, in the case of a crippled child, shield him from the prying and pitying eyes of friends and acquaintances. The child, who in hospital has been utterly unselfconscious of his deformity, finding himself an object of pity often has his mental outlook entirely changed and in some cases the change is so subtle that dire results may occur. Surely we can help here. Some breadth of the outside world must be brought into the homes we visit—something in which the patient is already interested, or in which he may become interested. Occupation and diversion of a sort which will not cause undue fatigue are absolutely essential. Games, radio, reading—all are helpful—anything to stimulate an interest outside himself.

If you were to come for a few moments to Victoria Hospital, London, and if you asked me to take you to the two cheeriest patients I should lead you to the two who are still in the respirators, a girl of eighteen and a boy of eighteen, both very badly paralyzed. The screen between them on their balcony would be covered with gaily coloured greeting cards. These are enjoyed by means of head mirrors and, with the assistance of their nurse they are engaged in a game of "easy money". The girl has made three thousand today and the boy is down, but he intends to beat her tomorrow. The good-natured rivalry is helping this courageous pair to face their future unflinchingly.

Then there are older patients, one a bride of a year, almost completely paralyzed, young married women with small children, all with family responsibilities. Can one hope to keep them bright and cheery? I must tell you of one patient to show you what can be accomplished. A health farmer of thirty-seven, stricken last year and now with considerable paralysis of both legs and the right arm, lies at home on his Bradford frame, wearing three splints. You may visit that home any day and find the large farm house beautifully clean and tidy and the patient perfectly cared for by his young wife. She has been up at dawn, done the washing, tidied the house, looked after the two-year-old child, her ten months old baby, the patient and his paralyzed aged mother. Yet she looks very pretty and attractive, and ready to enjoy the visit with the nurse. The patient you find in an optimistic mood—both delighted at the slightest sign of progress. He is doing well and his wife will not break down, firstly because she is happy and secondly because she is healthy. Obviously this man has a great deal in his favour because of the congenial home situation.

Sometimes conditions are less favourable. Recently a nurse found a man of thirty-two most depressed—paralysis of both arms and legs being the apparent reason—yet she suspected some other underlying cause. Finally the trouble was told—the engagement ring had been given shortly before the disease had made its attack and now the girl was miles away and he was paralyzed. Fortunately the fiancée lived in the nurse's district and she was able to arrange when passing that way to pick up the girl-friend, dropping her at the patient's house and calling for her later. His depression soon disappeared, he was inspired to make further effort and is now walking with the aid of a brace, has an ambulatory arm splint, and is progressing satisfactorily.

Our sympathies go to other members of the family too, for the feeling of despair which periodically attacks these patients is so understandable and yet so difficult to cope with. Home education is a great help. In larger centres, if ten children are found to require extramural education, a visiting teacher may be obtained. Then there is the education by correspondence carried on by the Provincial Board of Education. In some centres, art lessons are being arranged for those showing special ability. Reading desks, which are adjustable for bed patients, may be obtained from the Ontario Society for Crippled Children.

Many of the patients of last year's epidemic are now being allowed up and new problems present themselves. Carriages on which the patient may be placed on his frame can now be obtained and these give great pleasure to a child who has for the past eight months been looking at four walls only. Some of the parents make their own carriages, using perambulator wheels, a bit of gas pipe, automobile top material and a little bicycle enamel. One adult patient, who had benefited greatly from tank treatment during his hospitalization, was at a loss to know how he might derive the same benefit on the farm. He now lies on his frame on a bed in the front parlour, but the cattle trough has been cleaned and brought in beside him. It holds twenty gallons of water, he is lifted into it daily and has his hydrotherapy with very good results. Apparently there are no unsurmountable difficulties for those who are blessed with a bit of initiative.

Similarly, all the other needs can be met. Not one of us can say "There is no one to help in my community", for if there isn't it is our own fault, we haven't been able to find them. The child with polio has a particular appeal. When the family is unable to finance transportation, walking calipers, or extra nourishment, Service Clubs, Women's Institutes and other organizations are always eager to help. There may be people who will write letters to a lonely boy in the country, or a service club who will visit, and perhaps arrange for the aeroplane kit for which the boy has been longing. The Stamp Club, recently organized by the Ontario Society for Crippled Children, will give another interest to many.

Physical defects often bring with them a sense of inferiority and with that a desire to compensate. An understanding effort must be made by those entrusted with the child's care to see that such compensation reaches the proper balance and that it is directed into the right channels. Chronic illness often develops ambitions, and the child attains heights which he might not otherwise have reached. Regardless of the financial status of the family, his education should be along the lines which will best fit him for the future. The type of training he receives should depend upon whether his health and mental equipment will permit him to obtain a higher educational standing as a valuable asset for earning his living or whether he must support himself by manual labour. His pride in his work as he feels he is capable of accomplishing something becomes a valuable asset and consequently we must stress the positive side rather than the negative. What he *can* do is most important.

When a child returns to school after his long illness there may be difficulties and this is where there are great opportunities for the school nurse. The kindly teacher often showers attention upon him as the mother has at home. She may ask the boys to move along to make room for "poor little Jimmie" even though he himself doesn't want any of this "poor little Jimmie" stuff. The sooner we begin to treat our crippled children like normal ones the better. Jimmie will soon show Bill Jones that he can fight just as well with his left fist as Bill can with his right. He wants to be treated just like the other fellows because he *is* an ordinary fellow, after all.

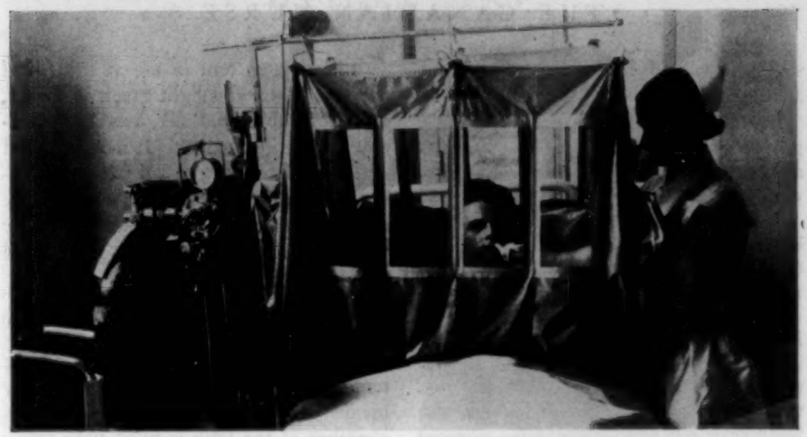
Let us do our best to make such a child self reliant and independent. We must never let him feel he has been cheated in life. In this competitive age it is sometimes a struggle even for the normal child to become self-supporting. How much more difficult is the path which the crippled child must tread. So with the aid of all available resources let us help him to take his full share in the life of the community.

Editor's Note: This article is based upon an address delivered by the author at the annual meeting of the Registered Nurses Association of Ontario at Kingston, in April, 1938.

ALBERTA ANNUAL MEETING

A combined Refresher Course and Convention, arranged by the Alberta Association of Registered Nurses, will be held October 5, 6 and 7 inclusive. The first day (Wednesday, October 5) will be spent at the Mental Hospital in Ponoka where lectures and clinics will be given by members of the medical and nursing staff. The second and third days (Thursday, October 6, and Friday, October 7) will be spent in Calgary at the Hotel Palliser. The programme will be most interesting and worthwhile to all members and it is hoped that everyone who can possibly attend will make an effort to do so.

Buses will be chartered in order to provide transportation to Ponoka from Edmonton and Calgary respectively. The business sessions will be held in Calgary.



The Heidbrink Oxygen Tent

THELMA McKENZIE

Surgical teaching supervisor, Royal Victoria Hospital, Montreal.

Until comparatively recently the administration of oxygen used to be considered almost an emergency measure for patients who were very ill. Today we are so accustomed to using it for therapeutic purposes, as well as in emergencies, that we consider it a common nursing procedure. The patient's attitude has also changed considerably. He used to be alarmed when told that he was to receive oxygen to help him to breathe, and, when the mask, catheter, or old type of tent was applied, he doubted if he would ever breathe naturally again. Hospital patients are now accustomed to seeing oxygen tents used frequently for those who are not always seriously ill, and, when they themselves have had the tent applied, and have experienced the relief and comfort that it gives, they do not need much further persuasion.

The types of cases in which the oxygen tent is most frequently used are:

1. For pneumonia patients, to relieve dyspnoea and cyanosis. Sometimes the patients are kept in the oxygen tent continuously for three or four days, while other patients only need oxygen for short periods at a time, depending on their condition.

2. In cardiac cases, such as heart block, or cardiac failure, to relieve dyspnoea and cyanosis and allow the patient to rest.

3. In cases of oedema of the lungs.

4. Post-operatively, after thoracoplasty operation, when the patient is cyanosed and breathing is difficult. It is also used for any post-operative patient who is not receiving sufficient oxygen.

5. In cases of asphyxiation.

Oxygen tents have passed through a period of transition and improvement, as has most of our modern hospital equipment. The Heidbrink oxygen tent, described in this article, has proved very satisfactory and displays the following advantages over the old type:

1. The tent is larger, thus giving the patient freedom to move. It also has numerous windows which permit him to see what is going on about him.
2. The patient is much more comfortable because the temperature of the air in the tent is recorded constantly and can be modified as desired.
3. The patient can be given nursing care in the tent, such as medications and feedings. The temperature, pulse and respirations may be taken by means of the sleeves that can be opened. The patient can also be given a bed pan without being removed from the tent.

Although the initial cost of this type of oxygen tent is relatively high, it is more economical to run than the old type. By regulating the correct amount, and the concentration of oxygen in the tent, no oxygen is wasted. In the old type of tent, a cylinder of oxygen would last twelve to fourteen hours, whereas in the Heidbrink tent, a cylinder will last from twenty to twenty-four hours, depending on the number of times the patient is removed from the tent. The tent comes in various attractive colours, and the psychological effect of a green or yellow tent is helpful and restful to the patient.

The Heidbrink apparatus is made up of the following parts, the respective functions of which should be clearly understood by the nurse:

Oxygen tent
Oxygen cylinder
Ice tank, ice chamber, drain, and drain pail
Motor blower
Rheostat
Thermometer
Damper
Regulator valve
Emergency valve
Flow meter
Soda lime attachment
Carbon dioxide attachment

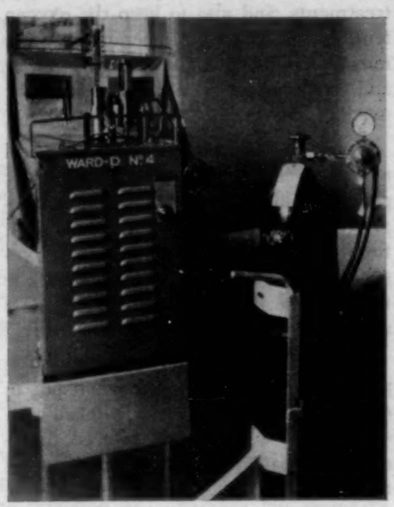
The oxygen tent in use at the Royal Victoria Hospital is light green in colour, made of rubberized silk, readily adjustable and easily cleaned. It may be raised or lowered to suit the height of the patient, by means of a handle on the ice tank. The rubberized silk is easily washed with soap and water and a mild disinfectant.

The *ice tank* is attached to the side of the tent and, in order that the oxygen may be cooled before entering the tent, it is forced through the ice tank by means of the *motor blower*. The ice chamber of the tank is filled with pieces of ice, three by six inches in size. This specific size is necessary because it affords a greater ice surface, thus causing the oxygen to be cooled more quickly. If the pieces are too small they melt too quickly and will block the drain at the bottom of the ice chamber. If properly filled, the tank will serve from eight to ten hours. The motor blower is regulated by means of rheostatic control. The *rheostat* is situated on the side of the ice chamber, and the higher the speed, the cooler the tent becomes. Usually, the patient is most comfortable at a temperature of 65° Fahr. The thermometer should not be allowed to go below 60° or above 70°. If the temperature does drop below 60°, there is a *damper* attached to the ice chamber, which can be adjusted by means of a push-rod. Pulling out the rod closes the damper, thus greatly reducing the circulation of oxygen. The motor-blower speed should be turned to low before the damper rod is pulled out to the extent necessary to raise the temperature of the air in the tent.

The concentration of oxygen is measured by taking a sample of air from a small opening at the top of the tent and analysing it by means of a special chemical analyser. There should be an average oxygen concentration of 50%, and it should not exceed 70%. The carbon dioxide content of the tent should not exceed 1½%. The concentration of oxygen can be regulated by the amount of air going into the tent. A small valve on the oxygen cylinder allows the oxygen to flow into the tent, and the number of litres of oxygen per minute is recorded on a *flow-meter* situated on the ice tank. Four to six litres of oxygen is the usual amount of oxygen per minute required for the patient, after the tent has been filled. This depends on the number of times the sleeves have to be opened to give treatments to the patient, or whether any leakage is present around the tent. By regulating the temperature of the air, and by testing the concentration of the oxygen, we are able to give the patient much more accurate and scientific treatment than by the old method.

The purpose of the *soda lime attachment* is to remove all the carbon dioxide from the tent. The doctors do not always use this because they feel that a small percentage of carbon dioxide is sometimes beneficial to the patient. There is also a carbon dioxide attachment at the back of the ice tank for the purpose of allowing the carbon dioxide content of the tent to be increased for those patients who are suffering from carbon monoxide poisoning or asphyxiation, and therefore should be encouraged to breathe more deeply.

Before the patient is placed in the oxygen tent, the treatment should be explained to him if he is able to understand, and his fears should be allayed. A rubber draw sheet is placed under the mattress to prevent the escape of oxygen through the mattress. The patient is placed between flannelette sheets and a nightingale is placed around the shoulders. The oxygen tent is then lowered over the patient's head by means of the hood-tilting device, and the skirt of the tent is tucked under the mattress and over the rubber draw sheet at the back and sides of the bed. At the front, the skirt is placed over the flannelette draw sheet and under the top bed clothes.



Oxygen cylinder and devices for control

Two nurses should be available when a patient is placed in the oxygen tent, or removed from it in order that treatments may be done. Time is thus saved and the patient is much more easily handled. The motor blower is first attached and then the oxygen cylinder is opened, the amount of oxygen going into the tent being regulated by the regulator valve. The emergency valve, at the back of the regulating valve, is also used to fill the tent more quickly by added pressure. This valve is used for one minute only. The rheostat is regulated to adjust the circulation for the desired temperature, and the flow meter is adjusted by the oxygen valve, after the concentration of oxygen has been taken. If possible, all necessary treatments should be done while the patient is removed from the tent, so as to give him more rest between treatments, and also to keep the oxygen tent at the desired temperature. The nurse should watch the patient's colour and respirations, and also adjust the oxygen tent when necessary.

Smoking, and the use of electrical appliances such as bakers and electric pads, should not be allowed near oxygen tents, as there is always danger of fire if a spark comes in contact with oxygen. "No Smoking" is printed on the front of the oxygen hood in red letters as a constant reminder of this danger.

Delirious patients and restless children present a nursing problem when put in oxygen tents and should be watched constantly. It is frequently noticed, however, that patients who are delirious and restless before oxygen is given, become quieter and more comfortable as the cool oxygen helps them to breath and improves their circulation. Sedatives are usually ordered by the physician.

Mild restraint is sometimes resorted to in severe cases, by the application of canvas sides to prevent the patient from falling out of bed. The skirt of the oxygen tent is tucked in so as to leave considerable slack which will allow the patient to move his arms about but will not allow the escape of oxygen.

After use, the oxygen tent and equipment should be cleaned and put away in good order, ready for instant use. The tent should be washed, inside and out, with warm green soap and water and a mild disinfectant solution. It should then be kept fully extended until thoroughly dry. The inside of the skirt should be dusted with talcum powder, the tent collapsed and thus made ready for storing in a cool dark room. The ice-chest should be emptied and rinsed with an odorless antiseptic solution and allowed to stand with the cover off until dry. The drain at the bottom of the ice-chest should be cleaned and always kept free from obstruction. The drain-trays, situated at the bottom of the drain for the purpose of catching the drippings while the drain pail is being emptied, can easily be removed to allow the drain to be cleaned. The drain pail should be emptied and dried well to prevent rust.

The oxygen cylinder should be replaced by a full cylinder, if necessary. Care should be taken not to turn the regulating valve off too tightly as this grinds it down and destroys the delicate mechanism. The soda lime basket, if used, should be emptied, washed, dried and replaced in the proper compartment. The motor should be oiled after each 1000 hours of operation.

A complete understanding of the operation of the oxygen tent and of its care ensures scientific and adequate treatment for the patient and conserves the efficiency of the equipment at a minimum expense.

WANTED

Applications will be received for the position of Assistant Instructress of Nurses in the Royal Inland Hospital, Kamloops, B.C. Duties to begin immediately.

Address applications to Miss H. MacInnes,
Superintendent,
Royal Inland Hospital, Kamloops, B. C.

Benign Hypertrophy of the Prostate

MARTHA WATT
Head Nurse, Men's Surgical Ward, Hamilton General Hospital

In male surgical wards one so often sees nurses, both pupil and graduate, dismayed because they know nothing about prostate cases. Because of such ignorance and of the non-intelligent manipulation of patients resultant from it, an attempt will be made in this article to explain the underlying pathological condition and the effects it will produce upon a patient. Once these are clearly understood, the nurse will realize that treatment is directed toward alleviation, and is not just a round of senseless chores.

Let us first consider the effects of benign prostatic hypertrophy and the ways and means that treatment is directed towards its correction. The prostate is a firm, partly glandular and partly muscular body which surrounds the male urethra at its origin from the urinary bladder. It is situated in the pelvic cavity, behind the lower part of the symphysis pubis, and in front of the rectum. It is about the size of a large horse chestnut and somewhat conical in shape. An indistinct median furrow on its under surface separates it into two lateral lobes. It presents for examination a base, an apex, a posterior, an anterior and two lateral lobes. The base, for the most part of its extent, is directed continuous with the wall of the urinary bladder. The posterior surface is separated by its sheath and some loose connective tissue from the rectum and is about 4 cms. from the anus. The anterior surface lies behind the symphysis pubis, from which it is separated by a plexus of veins and a quantity of loose fatty tissue. The lateral surfaces are prominent and are covered by the anterior portions of the levator ani muscle, which however are separated from the gland by a plexus of veins. Each gland is made up numerous branching tubular glands, which are embedded in and surrounded by non-striated muscle and fibrous tissue. The glands end in the urethra.

Enlargement of the prostate, while common in men over sixty, only produces symptoms in about eight percent of cases. It is essentially a disease of advancing years and the reason of the hypertrophy is unknown. It has no relation to infection or gonorrhea but seems to be a form of abnormal involution. The condition of the prostate varies, depending upon the proportion of glandular to fibrous tissue. Usually the enlargement is made up of a series of rather spongy nodules and the part of the gland containing the nodules enlarges so as to form a mass which compresses the surrounding tissue. In other cases there is diffuse fibrosis, rather than nodular hyperplasis, in which case no nodules can be seen. The lateral lobes may be enlarged or a new middle lobe may be formed by hypertrophy of the group of glands which lie in the floor of the urethra. This middle lobe forms a conical mass which projects up from the floor of the bladder, carrying the urethral orifice with it.

The following symptoms of enlargement of the prostate are due entirely to the position of the gland at the urinary outlet:

The prostatic urethra may be elongated, compressed to a mere slit and rendered tortuous. This is the most important cause of obstruction.

The bladder cannot be completely emptied because the urinary outlet is

lifted up above the surrounding floor and the enlarged middle lobe may exert a ball valve action. There is, therefore, a constant dribbling of urine without the complete emptying of the bladder. The residual urine is readily infected and cystitis results. The bladder becomes hypertrophied in its efforts to overcome obstruction. Later there is dilation, with pouching of the wall, producing false diverticulae.

The kidneys suffer because of this obstruction and infection. The ureter and renal pelvis on both sides are dilated so that hydronephrosis is produced. Infection ascends the dilated ureters and causes pyelonephritis. Renal insufficiency now declares itself. Non-protein nitrogen is retained in the blood stream. The back pressure on the kidney is associated with arterial hypertension, even though the kidney damage is very slight.

Diagnosis of prostatic hypertrophy is therefore made upon a history of difficulty in voiding, straining, urgency, dribbling of urine and residual urine. Digital and cystoscopic examination reveal the prostatic enlargement.

The treatment is directed towards the relief of associated symptoms, such as cystitis, dehydration and uremia. Relief of the hypertrophy itself is obtained by operation. On admission to the hospital, history having been obtained and physical examination completed, the patient is investigated for residual urine; urinalysis with special regard for pus, casts and albumen; blood examination; and non-protein nitrogen determination. The last two give fairly definite estimation of the extent of kidney damage. Cardiac damage, which may be resultant upon kidney malfunction, is also investigated. Then the usual procedure is the insertion of an indwelling catheter, thus allowing constant drainage of the bladder, affording relief of the patient's cardinal symptoms, and permitting irrigations towards an aseptic bladder. Indwelling catheters are of two types: (1) ordinary straight French catheter, which is held in place by means of adhesive or rubber tape; (2) a mushroom or pigtail variety. These are introduced by means of metal applicators and held in place by their shape. Even though the bladder is already septic, it is necessary to catherize under aseptic conditions.

Irrigations are usually done two or three times a day with a variety of solutions of appropriate dilution such as simple boracic; potassium permanganate; acriflavine; silver nitrate. Occasionally these irrigations are followed by retaining instillations of a solution of argyrol of appropriate strength. Irrigations are used at a temperature of 110° to 112° F. and are given until the return flow is clear. In combating cystitis, irrigations are supplemented by oral administration (as ordered) of urinary antiseptics, such as potassium citrate, hexamine, acid sodium phosphate and tincture of hyoscamus. More recently, sulphanilamide and syrup of mandelic acid have been extensively used.

Pre-operative patients are not necessarily bed patients. As they are usually aged and debilitated it is in fact advisable that they be ambulatory. Their diet is one of low protein, high caloric and high fluids. Fluids are supplemented by intravenous glucose and saline if oral intake not sufficient. This dietary control is an attempt to lower the non-protein nitrogen content of the blood. Intake and output are measured each twenty-four hours and an accurate record kept on special prostate charts, along with the urinalysis, blood chemistry and pressure which are re-checked at least twice a week.

Kidney function may further be studied by specific gravity kidney function tests. The technique of these is simple.

The total night urine (8 p.m. to 8 a.m.) is discarded. Specimens are collected every two hours for the next twelve hours and their specific gravity is determined. The total day urine is measured, and the total night urine is saved, measured, and its specific gravity estimated. The day urine should be approximately three times that of the night, and the daily specific gravity should vary at least from 10 to 15 points. A patient with severe kidney damage will show a fixed low specific gravity, with a night output equal to or greater than that of the day.

When the patient under observation shows clear urine, normal blood non-protein nitrogen, lowered blood pressure, catheter tolerance, and equilibrium of temperature for several days he is ready for the relief of obstruction by operation. Operations have now two main types of approach; the supra-pubic route where the whole gland is enucleated, and the trans-urethral resection, where the obstructing lobe is resected by means of cautery, through a cystoscope. The anaesthetic of choice for both is spinal anaesthesia.

The post-operative treatment is similar for both types of technique and is directed towards maintenance of free drainage and control of hemorrhage. Effort is made to control hemorrhage in supra-pubic operation by insertion of a rubber Pilcher bag. The principle of this is that a small rubber bag, conical in shape, is inserted into the cavity remaining after the enucleation of the gland and inflated with water, to maintain tension against the cavity. Tension is maintained by traction, through the urethra, by the stem of the bag held to a metal tripod. This bag is left in situ for twenty-four hours, after which time the fluid pressure is released and can be re-inflated at the appearance of hemorrhage. If no hemorrhage appears it is removed after forty-eight hours and replaced by urethral catheter.

Hemorrhage must be carefully watched in the drainage winchester. If persistent, hot continuous irrigations at 118° F. of mild solutions are used. If formation of clot is extensive, the wound is re-opened and the clots removed. In supra-pubic prostatectomy, treatment is directed towards maintenance of a dry incision. At the end of the first week the abdominal tube is removed and replaced by a smaller tube and the margins of the incision are drawn together by means of adhesive tape. Urethral drainage is kept up with frequent adjustments until the abdominal incision is definitely dry.

Trans-urethral prostatectomy is of easier attention. Hemorrhage is controlled by frequent irrigations of hot non-irritating solutions. Clots are removed by suction or broken up by hemolyzing solutions such as hydrogen peroxide. The catheter remains in place until hemorrhage has totally ceased for approximately two days. On the removal of catheters it is necessary to measure the output of urine very carefully and watch for retention.

The prostatic patient requires special care and attention on the part of the nurse. A number of factors influence his condition. There is usually present, in varying degrees, a mild mental depression. The patient may be morose, irritable and even slightly disoriented. A natural reticence and bashfulness, due to the nature of his trouble, makes the patient intensely sensitive. Both pre-operative and post-operative care necessitate a great deal of embarrassment, not always appreciated as it should be by busy and pre-occupied nurses. The patient's reception, care and treatment should be kindly and understanding. The patient likes to consider himself as an individual, not a bed with a number, a fact which is all too frequently submerged in the cold, routine of a modern institution. He should not be annoyed by petty hospital restrictions until he becomes more or less acclimatized to institutional routine.

Bladder drainage having been established, it is the nurse's responsibility to see that intake of fluids is great, at least 4000 c.c. a day. All fluids may be utilized and the patient should himself be interested in a variety, hot or cold, according to his preference. An accurate record is essential; the terms, "approximate" and "about" are annoying to the attending surgeon and are surely not adequate.

Daily cleansing and careful watching of drainage tubes and bottles is necessary. The tubes must be kept patent and free from kinking by clots. The tubing should be clamped when bottles are emptied and a pint of water should be kept in the bottle thus allowing the tube to be kept under water at all times and facilitating suction. Care and cleanliness in these details will help to eliminate odour. A well trained orderly, familiar with routine and equipment, is an invaluable asset. He should be responsible for the cleanliness of the perineum of the patient and for drainage conditions.

The prostate case, because of his long chronicity and painful, annoying symptoms, is naturally very enthusiastic about his own recovery. His gratitude will well repay the nurse for his exacting care.

REFRESHER COURSE IN TORONTO

A Refresher Course for registered nurses interested in Child Hygiene will be held October 19, 20, 21, 22, inclusive, under the auspices of the School of Nursing of the University of Toronto. The fee for the course will be $5.00. The general topic will be Changing Practices in the Field of Child Hygiene, including the prenatal, infant, preschool and school periods. An interpretation of the subject will be offered from the following points of view:

The Obstetrician: Dr. H. B. Van Wyck, Associate Professor of Obstetrics and Gynaecology, University of Toronto.

The Paediatrician: Dr. F. F. Tisdale, Associate Professor of Paediatrics and Director of Paediatrics, Research Laboratories, University of Toronto.

The Psychologist: Dr. W. E. Blatz, Professor of Psychology and Director of St. George's School for Child Study, University of Toronto.

The Nutritionist: Miss Marjorie Bell, Director Visiting Home Makers' Association, Toronto.

The Social Worker: Miss Frieda Held, Provincial Department of Public Welfare, Ontario.

The Educationist: Mr. Stanley A. Watson, Principal Essex School, Toronto, and Collaborator in Preparation of the new curriculum, Department of Education, Ontario.

Round Tables will give an opportunity for an application of this teaching to nursing in a discussion of the infant, the preschool child and the school child.

Applications for further information concerning the course should be made to the Secretary, School of Nursing, University of Toronto, Toronto, Canada.

WELCOME HOME!

"A journey of a thousand miles begins with a single step," wrote a Chinese sage many centuries ago. We wonder what would have been the feelings of Ruby Hamilton if, as a young probationer, she had been privileged to have a glimpse of the road ahead. That first step led from a peaceful Ontario village to the Johns Hopkins Training School in Baltimore. To start one's professional career under the direction of such leaders as Adelaide Nutting and Caroline van Blarcom, to know and work with Sir William Osler, Dr. Welsh, Dr. Kelly and Dr. Halstead—surely this was happy augury for the journey ahead. Following those memorable training days, the years held for the erstwhile probationer valuable experience as staff supervisor, private duty nurse, and night superintendent of Johns Hopkins Hospital.

Then the call came from overseas service, and another "Sister" was added to the Queen's University Unit. In France, at Number Seven Canadian General Hospital, two and one half years were spent on active service—until the arrival of an official envelope commanding Nursing Sister Ruby Hamilton to return at once to Canada as Matron of St. Anne de Bellevue Military Hospital in Quebec, meant another unexpected task and a fresh turn in the road. In 1920, when the military hospitals were still full but the mind of the public had turned again to peace and reconstruction, the Matron of St. Anne de Bellevue Hospital resigned and joined the new group of public health nurses, organized under the Ontario Department of Health, to blaze new trails.

Ruby Hamilton

Fourteen years ago response was made to another call, this time from the Canadian Red Cross Society. The trail led for eight years through Canada's Northland, during the early development of the Ontario Outpost hospitals, when Miss Hamilton served as supervisor of Red Cross public health activities. It was during this period that she was the favoured recipient of a Red Cross scholarship, and was registered during 1927 and 1928 at Bedford College of Nursing, London, England, for post-graduate studies in public health.

The many international contacts made while abroad, the varied experience in school work, and opportunities for overseas travel throughout the years, all served to make Miss Hamilton's appointment in 1932, as superintendent of Junior Red Cross in Ontario, a happy choice. No child (and no detail) has been too small to be given her personal attention when needed. Many crippled patients and their parents, throughout Ontario, will remember her with affection. Little Arthur, cruelly crippled a few years ago, but who now runs about like other boys, will miss a friend when he makes his periodical visits to Toronto specialists and Red Cross headquarters. And he is but one of many. The work Miss Hamilton is leaving is well organized, and there are now 155,322 Red Cross Juniors enrolled in 5,027 classrooms of Ontario — children striving with eighteen million other members throughout the world for the high ideals of health, service and world friendship.

This sketch of Miss Hamilton's nursing career would not be complete without mention of her personal contribution to professional organizations. Possessing a quiet, dignified manner and a sense of humour, she works well with others. In addition to holding office in the Registered Nurses Association of Ontario and serving on numerous committees, she has been the honoured president of the Toronto Community Health Association and the Toronto unit of the Overseas Nursing Sisters Association. As an "Old International" she has for the past five years served most successfully as convener of the Ontario Florence Nightingale Foundation committee.

Now, at her own request, another Canadian nurse is being released from professional duties and responsibilities. A gracious personality will be missed from the active ranks, but her friends and colleagues cannot help sharing her enthusiasm and joy in her plans for years in happy retirement. We feel certain that the little feathered friends perched on the edge of the bird pool sang more gaily, and the chimes of the Canterbury Bells pealed more sweetly throughout that peaceful Islington garden — echoing the good wishes of many friends — when they realized that one who had travelled along many roads in distant lands had at last come home "to stay".

T. C.

MISS DORSEY RESIGNS

We learn through *The British Journal of Nursing* that Miss Nan Dorsey, who for many years has served as Warden of the Florence Nightingale International House, has resigned and will soon return to the United States. Canadian nurses who have been residents will agree with the warm commendation given by Mrs. Bedford Fenwick to Miss Dorsey in these words:

> Miss Dorsey has welcomed students from all over the world, for many years made them feel at home in London, encouraged a fine spirit of comradeship amongst them, and is generally beloved. Her resignation, which takes place at the end of the year, is a real loss to the Foundation.

Notes From the National Office

Contributed by JEAN S. WILSON,

Executive Secretary, The Canadian Nurses Association

From the report of the nineteenth General Meeting of the Canadian Nurses Association, as published in the September number of the *Journal*, members of the Association are aware that the National Joint Study Committee of the Canadian Medical Association and the Canadian Nurses Association was disbanded. This Committee, organised in 1927, functioned under the able and sympathetic direction of Dr. Stewart Cameron, of Peterborough, as Chairman.

Permission has been secured from Dr. Cameron to publish the subsequent paragraph which formed part of his letter to the representatives of the Canadian Nurses Association when advising that, in so far as the Canadian Medical Association was concerned, the National Joint Study Committee was disbanded and that such action would be completed when the Canadian Nurses Association also agreed to disbanding:

> And so time moves on, almost ten years have passed since we began this job. The final acts are about to be completed. I think something was done that I believe will be for the benefit of the Canadian nurses, not so much perhaps as was hoped for at first. At least a foundation was laid upon which your profession can build with more security than they could have done without the Survey.
>
> The Canadian Medical Association was glad to have had a part, although a small part, in the work. If in the future, you should desire the help of our Association I am sure you have only to ask and that help will be forthcoming. Might I suggest that in some way you maintain the connection that has been established so that your activities may be kept before our profession and in some degree co-ordinated with ours. Not the least of the accomplishments of the joint committee was the recognition by the Canadian Medical Association of the important place Nursing has in the care of the health of the people. I trust that this may continue.

An Historical Record

The first Oration in honour of Florence Nightingale was delivered by Sir George Newman during the ninth Quadremmial Congress of the International Council of Nurses. The Florence Nightingale International Foundation secured permission to publish the text of the Oration in pamphlet form.

For the convenience of all those in Canada who may wish to secure the pamphlet, the Canadian Nurses Association ordered a supply of copies which can be obtained at the National Office, 1411 Crescent Street, Montreal. Single copies ten cents; or lots of 12 copies for one dollar.

The text of the Oration should prove valuable to students of the history of nursing and might very well be found in all schools of nursing. Please do not delay in ordering one or more copies as the supply at National Office is limited.

C. N. A. Scholarship

Miss Bianca M. Beyer, who was awarded the Canadian Nurses Association Scholarship, 1938-1939, wrote the following letter, under date of August 28, 1938, to the Executive Secretary:

It is with pleasure that I write to inform you and the members of the Canadian Nurses Association, that I arrived in London on August 14 and am very comfortably settled in "Canada Room" at 15 Manchester Square. The room, with its cheerful colouring of yellow and brown, its pictures of Canadian scenes, looks like a little corner of home and makes me feel very welcome. I know that I shall be comfortable and happy here.

It is most interesting to meet nurses from fourteen other countries and to realize that we have common interests. Already, these interests have drawn us together and we feel like old friends. The countries represented this year are: Great Britain, South Africa, Australia, India, United States of America, Norway, Sweden, Denmark, Holland, Latvia, Poland, Finland, Turkey, China and Canada. Miss Parsons, Miss Baggallay and Miss Dorsey are very kind and most gracious. We are enthusiastically looking forward to an interesting as well as a profitable year, for we hope to become acquainted with London, as well as with the hospitals and nursing schools.

At the present time I am in residence, with the student from Norway, at the University College Hospital. I spend two weeks at St. Thomas's, a week at the Middlesex and a week at St. Mary, Islington Hospital before the university term opens on October 6.

May I take this further opportunity to thank the members of the Canadian Nurses Association for making it possible for me to represent them at the International Course, and to assure them that I will endeavor to do so worthily.

Nightingale Memorial Fund

Further contributions to the Florence Nightingale Memorial Fund have been received as follows: Nursing Staff, Victorian Order of Nurses, Montreal, $9.00.

A request has been received for the correction of an item as published with the list of donations in April 1938. The item was entered as: "Interested Married Nurses, Edmonton, $26.00"; this should have read "Interested Married Nurses, Alberta, $26.00."

The Curriculum

A reprinting of *A Proposed Curriculum for Schools of Nursing in Canada* is now available. Copies can be obtained from the Canadian Nurses Association, 1411 Crescent Street, Montreal, P. Q. Price: One dollar a copy.

OBITUARIES

Georgina Pope, a member of a distinguished Canadian family, died on June 6, 1938 at Charlottetown, Prince Edward Island. Miss Pope, who was a graduate of the school of Nursing of Bellevue Hospital, New York, rendered outstanding military nursing service, both in the South African campaign and during the Great War. In January 1936, the occasion of her golden jubilee of professional service was celebrated under the auspices of the Alumnae Association of the School of Nursing of the Charlottetown Hospital. An account of this event and further details concerning Miss Pope's interesting career will be found in the February, 1936, issue of this *Journal.*

Eileen Potts, a graduate of the School of Nursing of the Royal Victoria Hospital and a member of the Class of 1932, died on August 27, 1938, in the Ross Memorial Pavilion of the Royal Victoria Hospital.

The Student Nurses' Page

At the Biennial Meeting of the Canadian Nurses Association there was a lively debate about the best way to make the *Journal* "come alive". Upon one point everybody was in agreement—there ought to be a student nurses' page. While this argument was going on we kept quiet as a mouse and did not even mention that not so long ago there used to be a students' page. Nobody asked what had become of it. No one even remembered it had ever been there. But we did. So here is our side of the story.

We struggled quite valiantly with that page and tried to keep it in the *Journal* even when it was difficult to find space for it. The real trouble was that the material sent in for publication was not suitable. Usually it took the form of interminable case histories which took up far too much space and which it was difficult either to condense or to edit satisfactorily. Sometimes we opened a fat and promising envelope only to find that it contained trivialities about Hallow'een or Christmas parties, complete with costumes and table decorations. Very seldom did we ever receive anything which brought the challenge of youth with it. New ideas, a fresh point of view — we looked for them in vain.

We can hear you saying — "Well, what does the *Journal* want?" We can answer that question in a single sentence: "The *Journal* wants material which reflects the original thinking and the actual experience of student nurses". Preferably (though not necessarily) this material should be directly related to nursing. Articles should not exceed one thousand words and should be typed or legibly written. They should be approved by the superintendent of nurses, or by a responsible member of the teaching staff of the School. They must be signed by the author.

You must not feel hurt if your first effort is not published. The editor, poor soul, has to decide whether it is readable or not. Don't ask how she does it. She won't tell you. Try again. In writing as in everything else, practice makes perfect.

Now what topics can you find? How about your last "turn" on night duty? What did you learn? What did you wish you *had* learned?

Why didn't the pneumonia case you worked so hard over, get well? What are you going to watch for next time? Was there anything you missed?

If you were the head nurse what would you teach the students on your ward — and why?

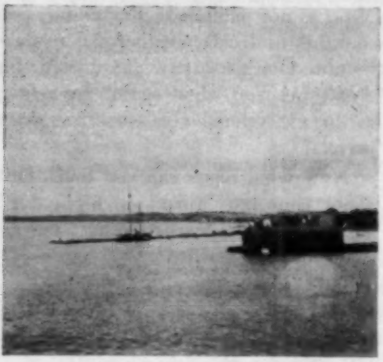
What do you think about student councils? Is there any form of student government which really governs? If not, why not?

What ideas have you about the social life of the residence? What about a dramatic group which might work up living pictures of the history of nursing for the next Alumnae meeting? Or a glee club? Or outdoor sports in which you could challenge the student nurses in the other hospitals?

There are other and more far-reaching possibilities. There is this whole difficult question of personal conduct and good manners. If the old discipline is to pass, what do you suggest should take its place? Should more be expected of the student nurse than of other young women? If so, where are you to look for strength and inspiration?

The student nurses' page lies open before you. What are you going to write upon it? You can say a great deal if you use a thousand words. Sometimes you can say more if you boil it down to five hundred. Just one word more — no poems, please. Positively no poems. We just can't bear them.

P.E.I. REFRESHER COURSE



Charlottetown Harbour

Under the auspices of the Prince Edward Island Registered Nurses Association a two-day Refresher Course for graduate nurses is being offered on Monday, October 17 and Tuesday, October 18 at Charlottetown. The principal speaker will be Miss Katharine M. MacLennan, B. A., assistant superintendent of nurses and instructress at the Alexandra Hospital, Montreal. Arrangements have also been made for other interesting addresses. The tentative schedule is as follows:

Monday (Morning Session)

The value of a General Education: Dr. G. D. Steele, Principal, Prince of Wales College.

General Education for Nurses: Rev. Sister Loyola, Charlottetown Hospital. A theoretical Basis for Medical Asepsis: Miss Katharine M. MacLennan.

Monday (Afternoon Session)

Some Aspects of Immunization: Miss K. MacLennan.

Progess in Immunization in Prince Edward Island: Miss Mona Wilson, Director of Public Health Nursing, P.E.I. Department of Health.

Monday (Evening Session)

Medical Asepsis, as carried out at the Alexandra Hospital, Montreal: Miss K. MacLennan.

Demonstration of medical aseptic technique applied to home environment: Miss Ruth Ross, public health nurse, P.E.I. Department of Health.

Tuesday (Morning Session)

Scarlet fever and diphtheria—onset, general course and complications: Dr. Simpson, member of the medical staff of the Prince County Hospital, Summerside.

Nursing care in these and other infectious diseases: Miss K. MacLennan.

Tuesday (Afternoon Session)

New Drugs: Dr. Wendall Mackenzie, member of the medical staff of the P.E.I. Hospital.

Pre-natal Care: Miss Reid

Demonstration of preparation for delivery in the home: Miss Solomon, Charlottetown Hospital.

Enquiries regarding the course should be addressed to the Rev. Sister Stanislaus, president of the Prince Edward Island Registered Nurses Association, Charlottetown Hospital, Charlottetown,

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ONE OF "OURS"

Mr. Asa S. Bacon, superintendent of The Presbyterian Hospital of the City of Chicago, has authorized the publication of the following announcement:

Miss M. Helena McMillan announces her retirement, in October, as Director of the School of Nursing of The Presbyterian Hospital of the City of Chicago. When the hospital decided to establish its own School of Nursing in 1903, Miss McMillan was selected to take charge of the new project. She had been graduated from McGill University, Montreal, and the Illinois Training School for Nurses and was at that time a resident of Henry Street Settlement in New York.. Previously she had organized the School of Nursing at Lakeside Hospital in Cleveland, Ohio, and for two years was superintendent of nurses in the Kingston General Hospital, Kingston, Ontario. To Miss McMillan was assigned the task of organizing the School, and the dual role of director of the educational programme and the nursing service in the Presbyterian Hospital. Her success in co-ordinating the two programmes is attested by the record of her 35 years of service and the recognition accorded her as a leader in the field of nursing education. In 1936, Miss McMillan was the recipient of the Saunders Medal.

Canadian nurses still claim Miss McMillan as one of our own and are proud of her fine record as an administrator and educator. Their best wishes will follow her in her retirement.

"INTERNATIONAL AFFAIRS"

These delightful verses, written by Florence Heaney (Great Britain), a student from 1937 to 1938 in the courses offered under the Florence Nightingale International Foundation, are quoted from *"The International Times"*, a notable publication to which more extended reference will be made in a later issue.

I like Americans
They are so keen to get and go,
And knowing what they want to know,
Waste not their powers in further search
For that ideal which is theirs already.
With forks their energy conserve
Why use two hands when one will serve
To satisfy the pangs of hunger.

I like the Finns
They are so patient and so fair
So much to give so much to share.
The coffee pot has one cup more
For all who come to join the throng.
I would I could their minds explore
For wealth of Finnish song and lore
And stores of thoughts forever fresh.

I like the Swedes
They are so young and very keen.
I think it would be hard to wean
Their thoughts from cost of living budgets,
Allowances and convalescences,
And yet it seems that they have time
To study also source of crime
And render aid by social service.

I like Chinese
Who grace this place with costumes fair.
They always seem to have to wear
A garment fitting for the occasion.
They understand their fellow men,
Intelligence testing as a natural feature
Of calculating the normal creature
Is play to them.

I like these Folks
I've mentioned here.
Their characteristics might appear
As somewhat lacking in myself
And counteracting this defect
To keep my head and still be rational
I sign myself an *"International"*.

PRIVATE NURSING IN NOVA SCOTIA

The following report, prepared by Miss E. Irene Smith, convenor of the private duty section of the Halifax branch of the R.N.A.N.S., gives an excellent picture of the work of an active and enterprising group.

During the last two years there has been an increase in employment. A number of nurses have taken and are taking, postgraduate courses in Quebec and Ontario institutions. A few nurses have engaged in institutional work in the United States during the past year. Reorganization of registries has not been undertaken.

Although twenty-four hour duty has recently been completely abolished in Halifax, it is still being practised in many Nova Scotia Hospitals. Considerable dissatisfaction has been noted among our private duty nurses because of their long hours of duty and low incomes as compared to other groups in our own Province. Three districts have been making an effort to adjust this situation; Valley Branch is considering a ten-hour day; New Glasgow an eight-hour day; in Halifax eight-hour duty has been established since July 1, 1938. Investigation of conditions of private duty nursing in Halifax during 1937, shows that the average number of hours of duty was 2,268. The average income was $654.00, or 28.9 cents per hour; the amount of fees not collected was $21.00; the amount of service given free was 7 days, that is almost one month's salary was given free for the benefit of the public. Among 98 nurses, 23 have life insurance policies, 2 policies being dropped during 1937. One nurse carries a sickness policy.

To determine the value at which the general public estimates nursing service in Nova Scotia, the initial minimum salary and hours of duty of institutional nurses in Halifax hospitals, supported by the Dominion Provincial and City governments, has been ascertained. The average number of hours of duty is 2524 per year, (256 hours more than the private duty nurses); average yearly income is $1385.00 or 55 cents per hour, or 26¢ per hour more than private duty nurses. This is only approximate salary, allowing $8.00 per week for board and $60.00 per year for laundry. In many cases these groups are also assured of a month's salary if ill, and of free hospital care. From the records of private duty nursing at our two largest hospitals, where both day and night nurses are employed, the duration of the average case is 8 nights and 11 days. On the basis of our former schedule, 8 nights at $4.00, and 2 meals at 35¢ for each twelve-hour period cost $37.60; 11 days at $4.00, and 2 meals at 35¢ for each twelve-hour period cost $51.70. The total cost to the patient was $89.30. The earnings of the nurses for the 19 periods of twelve-hour duty was $76.00. On the basis of the schedule in force since July 1, we find that the cost to the patient is $88.20 distributed as follows: 7 a.m. to 3 p.m.—11 periods @ $3.75, plus 1 meal @ 35¢ $45.10; 3 p.m. to 11 p.m.—8 periods @ $3.75, plus 1 meal @ 35¢ $30.80; 11 p.m. to 7 a.m.— 3 periods @ $3.75, plus 1 meal @ 35¢ $12.30. The total cost to the patient is therefore less than on the previous schedule. The earnings of the nurse for the 22 periods of 8 hours each were $82.50, an increase of $6.50 which must provide for the 16 extra meals previously paid for by the patient. Sixteen meals, at 35¢, would cost $5.60, therefore the extra value to the 3 nurses employed is 90¢ during average cases.

Considering, therefore, the financial condition of those from whom our income is derived, the cost of living in the locality concerned, and the standard of living demanded of us as professional people, the following recommendations of the private duty nurses of the Halifax Branch were approved by the Registered Nurses Association of Nova Scotia at the Provincial annual meeting on June 3, 1938.

1. That 24 hour duty be abolished.
2. That 8 hour duty be instituted in hospitals.
3. That the eight-hour and twelve-hour schedules be optional in homes.
4. That the fee for eight-hour duty be $3.75 for general nursing.
5. That the fee for twelve-hour duty be $5.50 for general nursing.

6. That a fee of $1.00 extra per 8 or 12 hour period be charged for mental and alcoholic cases outside of hospitals.

7. That each nurse do only one period of duty in 24 hours.

8. That an investigation be made one year after the institution of this schedule to determine the average salary of the private duty nurse which may be compared to the average salary of 1937.

The Halifax hospitals have fully co-operated in order to enable us to carry out this schedule and with the exception of a few, doctors seem to approve of it. Should this schedule not show improvement financially , but even an improvement in the health of the nurses, and give each an opportunity to live like other people, we shall have a more happy and contented group and consider this schedule successsful.

VICTORIAN ORDER OF NURSES

Transfers:

Miss Margaret Hardy: transferred from York Township to Pictou; Miss Georgina Carr: transferred from the Toronto staff to take charge of the recently organized Peninsula Branch at Thorold-Merritton; Miss Mary Ross: transferred from Kingston to Cornwall; Miss Rachel Doull: transferred from Regina to Kingston; Miss M. MacNeil: transferred from Glace Bay to Halifax.

Admissions:

Miss J. L. Cunningham: admitted to Kingston staff; Miss J. Wallace: admitted to Moncton staff; Miss Margaret Perley: admitted to York Township staff; Miss L. Lawder: admitted to Cobalt; Miss H. Robson: re-admitted to Border Cities staff; Miss Helen O'Meara: re-admitted to Ottawa staff.

Resignations:

Miss Vera Webb: resigned from Cornwall; Miss M. Chepesiuk: resigned from Cobalt; Miss L. M. MacMillan: resigned from Glace Bay; Miss M. McIntosh: re-

A Tree of Life

Under the shade of this tree, Florence Nightingale taught her Sunday School class, in the beautiful grounds of her home at Embley Park. The illustration is made from an original photograph, taken by Cory M. Taylor. Copies, 5× 5½ inches, printed on sepia paper, suitable for framing, may be obtained securely packed and post-free from:

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signed from Glace Bay; Miss E. Corbett: resigned from Kingston; Miss J. Moody: resigned from Winnipeg; Miss J. MacFarlane: resigned from Kitchener; Miss M. Van Scoyoc: resigned from Hamilton; Miss Reta Myers: resigned from Moncton; Miss D. LaBrosse: resigned from Lachine.

ONTARIO PROVINCIAL PUBLIC HEALTH NURSING SERVICE

The child health programme developed and for years sponsored by the Child Welfare Association of London has been taken over by the City Department of Health. Reorganization of the public health nursing service has been carried out during the summer months and Miss Hilda Pennock of the supervisory staff of the Ontario Department of Health, has been the acting director. School health services are provided by the Public and Separate School Boards.

The public health nursing services of the Board of Health and the School Board of York Township have been amalgamated. There is now a staff of nine nurses with Miss Jean Watt as senior nurse. Miss Margaret King, formerly senior nurse for the Board of Health, resigned in July.

Miss Gladys McDonald, director of public health nursing in the recently amalgamated service of the Regina Department of Health, visited the Health Departments of Hamilton, London and Toronto during July and August.

Miss Katherine McRae, (Institute of Public Health, University of Western Ontario), who has been the public health nurse at Renfrew for several years, resigned in July.

Miss Oweita Clark, (School of Nursing, University of Toronto), has resigned her postion with the Cornwall Board of Health.

Miss Jean Fox, (S. of N., U. of T.), senior nurse with Oshawa Board of Health, resigned in August. She is succeeded by Miss Isabel Pringle, (I. of P.H., U. of W. O.), Miss Gertrude Tucker, (I. of P. H., U. of W. O.), recently resigned as public health nurse at Bowmanville, has been appointed to the Oshawa staff.

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Miss Lauretta Hall, (S. of N., U. of T.), public health nurse with the Public School Board of Brockville, resigned in June to accept a position as staff nurse with the Department of Health at Timmins, Ontario. Miss Eleanor Earle, (S. of N., U. of T.), who succeeds Miss Hall, resigned as senior public health nurse at Woodstock.

Miss Hilda Friendship, who resigned in June from the staff of the public school health service in Kingston, is succeeded by Mrs. Sara Verrall formerly with the Humber Bay School Board. Miss Friendship and Mrs. Verrall were students at the 1934 summer course in School Nursing given by the Ontario Department of Education at Hamilton.

Miss Jean Algie, (S. of N., U. of T.), has resigned as public health nurse of Fort Frances where she will continue to live after her marriage. Her successor is Miss Marion Thompson, a graduate of the School of Nursing of the Toronto General Hospital, and the Public Health Nursing Course, (1937) School of Nursing, University of Toronto.

OVERSEAS NURSING SISTERS ASSOCIATION

The Victoria Unit of the Overseas Nursing Sisters Association of Canada held a garden tea, in the late summer, at the home of Mrs. David Spencer. Twenty-nine Sisters were present including Miss Jordan from Honolulu, Mrs. Rhoads, Santa Ana, and Mrs. Morse, Port Angeles. The president, Mrs. R.A.C. Hogarth welcomed home Miss Agnes Forbes and presented Miss Ada Benvie with an attractive watercolour.

The Nursing Sisters Branch of the Canadian Legion, B.E.S.L. sent Miss K. E. Gray as their official delegate to the provincial convention in Vancouver. Matron Turner of Shaughnessey Military Hospital was the delegate from the Vancouver Unit of the O.N.S.A. These delegates served on the committee for pensions and treatment.

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NEWS NOTES

NEW BRUNSWICK

SAINT JOHN:

The fiftieth anniversary of the founding of the Saint John General Hospital Training School for Nurses was celebrated recently in the Admiral Beatty Hotel. The Alumnae Association entertained the thirty-three members of the graduating class of 1938. The president of the Association, Mrs. A. L. Donovan, presided and seated at the head table were the officers and special guests. The officers included the honourary president and past superintendent, Miss E. J. Mitchell; the president, Mrs. A. L. Donovan; the first vice-president, Miss Belle Howe; the second vice-president, Miss Susanne Hartley; the treasurer, Miss Rheta Wilson; the secretary, Miss Mary Crossman. Among the special guests were Mrs. Susan H. Sutherland, a member of the first graduating class; Mrs. J. McLellan, lady commissioner of the Hospital; Mrs. S. R. D. Hewitt, wife of the general superintendent; Mrs. Ralph Robertson, president of the Women's Hospital Aid; Miss Margaret Murdoch, superintendent of nurses. Past Presidents of the Alumnae, including Mrs. John H. Vaughan; Mrs. F. M. McKelvey, Mrs. Leonard Dunlop, Mrs. D. C. Malcolm, Mrs. O. A. Burnham. Miss Maude Retallick, (formerly superintendent of nurses), Mrs. Austin Powers, president of St. Josephs Alumnae Association and Mrs. G. E. Van Dorsser, president of the New Brunswick Association of Registered Nurses were also honoured guests. Following the dinner, bridge and dancing were enjoyed.

The regular monthly meeting of the Saint John Local Chapter of the N.B.A.R.N. was held recently with the president, Miss Margaret Murdoch, in the chair. Following the business meeting Dr. Geo. Skinner gave an interesting lecture on chest surgery.

Miss Jean Anderson McCready (S.J.G.H., 1938) has left for the Royal Victoria Hospital, Montreal to take a post-graduate course in obstetrics. Miss Sarah Cohen (S.J.G.H., 1938) has accepted a position at the Jewish Hospital, Montreal.

Married: On May 23, 1938, Miss Vesta Muriel Wiggins (S.J.G.H., 1935) to Dr. Esmond Stiles.

Married: On May 23, 1938, Miss Mabel Janet Price (staff of the Tuberculosis Hospital, East Saint John) to Mr. Kenneth Fowler Hargrove.

Married: Recently, Miss Kathleen Wilson (S.J.G.H., 1935) to Mr. William Burnside.

NOVA SCOTIA

AMHERST:

At the recent annual meeting of the Cumberland Branch, Registered Nurses Association of Nova Scotia, the following officers were elected: President, Miss J. S. Betz, of Amherst; vice-president, Sister Anna, of Springhill; secretary-treasurer, Miss Sally Lavers, of Amherst. Eleven meetings were held during the year, several of which were addressed by local doctors. One meeting took the form of a picnic at the Experimental Farm, Nappan, at which time a report of the C.N.A. Biennial Meeting was given by Miss Grace Smith, past president and delegate.

HALIFAX:

Miss Rose Creaser, who has been assistant supervisor of the main operating room, Victoria General Hospital, has been appointed supervisor of the operating room at the Blanchard Fraser Memorial Hospital, Kentville. Miss Madeline Millard has also been appointed to the nursing staff of this hospital.

Miss K. MacNeil has been transferred from Glace Bay to the staff of the Victorian Order of Nurses in Halifax.

Miss Maude MacLellan (V.G.H.), formerly supervisor of the paediatric department of the Victoria General Hospital, has accepted the position of superintendent at the Digby General Hospital.

Married: On August 16, 1938, Miss Margaret Taylor (V.G.H.) to Dr. Kenneth Grant.

ONTARIO

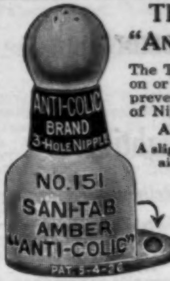
DISTRICT 8

OTTAWA:

Ottawa Civic Hospital:

Miss Leila Porter and Miss Marguerite Christie, (O.C.H., 1937) have left for Hamilton, Bermuda, where they will do general duty at the King Edward VII Hospital. They will be joined by Miss Bessie Pepper and Miss Alberta Gough.

Lady Stanley Institute: Miss Mabel M. Stewart was re-elected president of the Lady Stanley Institute Alumnae Association at the annual meeting held in the Royal Ottawa Sanatorium. Miss Stewart presided over a large attendance and excellent reports were read. Associated with Miss Stewart will be: vice-president, Miss C. Pridmore; secretary, Miss C. Ferguson; treasurer, Mrs. N. Halkett; Board of Directors: Mrs. G. C. Bennett, Mrs. W. E. Cavan, Miss C. D. Flack, Miss E. MacGibbon. The conveners of committees are: Flowers, Miss E. M. Booth; Press, Mrs. L. R. Gisborne; Central Registry Representatives: Miss M. Slinn, Miss E. Curry.



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REGISTRATION OF NURSES
Province of Ontario

●

EXAMINATION
ANNOUNCEMENT

●

An examination for the Registration of Nurses in the Province of Ontario will be held in November.

Application forms, information regarding subjects of examination and general information relating thereto may be had upon written application to:

ALEXANDRA M. MUNN, Reg. N.,
Parliament Buildings, Toronto

QUEBEC

MONTREAL:

Royal Victoria Hospital:

Miss Gertrude Yeats (R.V.H., 1920) has resigned from the teaching staff of the Royal Victoria Hospital to take up duties as clinical supervisor at the Vancouver General Hospital.

Miss Dorothy Riches (R.V.H., 1932) has accepted the position of instructor of nurses at the Provincial Royal Jubilee Hospital, Victoria, B. C.

Miss Molly Stevens (R.V.H., 1932) has resigned from the staff of the Montreal branch of the Victorian Order of Nurses in order to accept an appointment with the Amherst branch of the Order.

Miss Hazel Hay (R.V.H., 1932), who has been on the staff of the Women's Pavilion, has accepted a position at the Groote Schuur Hospital, Capetown, South Africa.

Miss Helen Eberle (R.V.H., 1929) has resigned from the staff of the Neurological Institute and is succeeded by Miss Bertha Cameron (R.V.H., 1931). Miss Lorraine MacNichol (R.V.H., 1934) succeeds Miss Cameron as night supervisor.

Married: Recently, Miss Florence Jamieson (R.V.H., 1933) to Dr. Harold Lyons.

Married: Recently, Miss Lucie Millette (R.V.H., 1935) to Dr. O. W. Stewart.

Married: Recently, Miss Jean A. Algie (R.V.H., 1930) to Mr. T. B. Harrison.

Married: Recently, Miss Ella Larsen (R.V.H., 1930) to Mr. Percy M. Crosbie.

Married: Recently, Miss Ella Wallace Jackson (R.V.H., 1933) to Mr. T. B. Manning.

Married: Recently, Miss Helene Wilson (R.V.H., 1931) to Mr. Gerald Dulmage.

Married: Recently, Miss Dougal Fisher (R.V.H., 1936) to Mr. Charles Turnbull.

MONTREAL:

Montreal General Hospital:

During the Biennial Meeting of the C.N.A. held in July in Halifax, a delightful reunion dinner of M. G. H. graduates (about 30) was held at the Cornwallis Inn, Kentville.

Miss Margaret J. Denniston (M.G.H., 1929) has been appointed assistant superintendent of nurses in the University of Alberta Hospital, Edmonton, Alberta.

Miss Louise M. Shepherd (M.G.H., 1928) and Miss Grace K. Reinauer (M.G.H., 1929) have been appointed to the staff of Jeffery Hale's Hospital, Quebec City.

Miss Mabel A. Shannon (M.G.H., 1932) a member of the night staff of the Central Division, for the past four years, has been

(*continued on page* 624)

Official Directory

International Council of Nurses

Executive Secretary, Miss Anna Schwarzenberg, 51 Palace Street, London, S.W.1., England

CANADIAN NURSES ASSOCIATION

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Alberta: (1) Miss Kate S. Brighty, Administration Building, Edmonton; (2) Miss H. S. Peters, University Hospital, Edmonton; (3) Miss R. Chittick, Normal School, Calgary; (4) Mrs. M. Tobin, 385-4th Street, Medicine Hat.

British Columbia: (1) Miss G. M. Fairley, General Hospital, Vancouver; (2) Miss A. Cavers, Vancouver General Hospital; (3) Miss M. Kerr, Eburne; (4) Miss M. Teulon, 4237 Granville St., Vancouver.

Manitoba: (1) Miss Edith McDowell, Nurses Residence, General Hospital, Winnipeg; (2) Miss F. Roach, St. Boniface Hospital, St. Boniface; (3) Miss A. McKee, 604 Medical Arts Building, Winnipeg; (4) Miss T. Greville, 797 Broadway, Winnipeg.

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Prince Edward Island: (1) Sr. Stanislaus, Charlottetown Hospital, Charlottetown; (2) Miss Anna Mair, P. E. I. Hospital, Charlottetown; (3) Miss Ina Gillan, 227 Kent St., Charlottetown; (4) Mrs. Lois MacDonald, 45 Upper Prince Street, Charlottetown.

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Executive Secretary: Miss Jean S. Wilson, National Office, 1411 Crescent St., Montreal, P.Q.

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